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1.1	Department of Labor and Industry			
1.2 1.3	Proposed Permanent Rules Relating t Parameters	o Workers' Cor	npensation; Treatmo	ent
1.4	5221.6040 DEFINITIONS.			
1.5	[For text of s	ubps 1 to 8, see	<u>M.R.]</u>	
1.6	Subp. 8a. Medical contraindication	. "Medical contr	aindication" means a	condition
1.7	that makes the use of a particular treatm	ent or medication	n inadvisable because	e of an
1.8	increased risk of harm to the patient.			
1.9	[For text of su	ibps 9 to 13, see	<u>M.R.]</u>	
1.10 1.11	5221.6050 GENERAL TREATMENT TREATMENT; PRIOR NOTIFICATI		RS; EXCESSIVE	
1.12	Subpart 1. General.			
1.13	[For text o	f item A, see M.	<u>R.]</u>	
1.14	B. The health care provider must	evaluate at each	n visit whether initial	
1.15	nonsurgical treatment for the low back, o	cervical, thoracic	, and upper extremity	<u>, complex</u>
1.16	regional pain syndrome, reflex sympathe	tic dystrophy, ca	usalgia, and cognate	conditions
1.17	specified in parts 5221.6200, 5221.6205,	5221.6210, and	5221.6300, and 5221	<u>.6305, </u> is
1.18	effective according to subitems (1) to (3)	. No later than a	ny applicable treatme	nt response
1.19	time in parts 5221.6200 to 5221.6300 52	<u>21.6305</u> , the hea	lth care provider mus	t evaluate
1.20	whether the passive, active, injection, or	medication treat	tment modality is resu	ulting in
1.21	progressive improvement as specified in	subitems (1) to	(3):	
1.22	[For text of subi	tems (1) to (3), s	ee M.R.]	
1.23	[For text o	f item C, see M.	<u>R.]</u>	
1.24	[For text of s	ubps 2 to 8, see	<u>M.R.]</u>	

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Subp. 9. Prior notification; health care provider and insurer responsibilities.
Prior notification is the responsibility of the health care provider who wants to provide the treatment in item A. Prior notification need not be given in any case where emergency treatment is required.

2.5

[For text of items A and B, see M.R.]

C. The insurer must provide a toll-free facsimile and telephone number for 2.6 health care providers to provide prior notification. The insurer must respond orally 2.7 or in writing to the requesting health care provider's prior notification of proposed 2.8 treatment in item A within seven working days of receipt of the request. Within the seven 2.9 days, the insurer must either approve the request, deny authorization, request additional 2.10 information, request that the employee obtain a second opinion, or request an examination 2.11 by the employer's physician. A denial must include notice to the employee and health care 2.12 provider of the reason why the information given by the health care provider in item B 2.13 does not support the treatment proposed, along with notice of the right to review of the 2.14 denial under subitem (3). 2.15

2.16

[For text of subitems (1) to (4), see M.R.]

(5) If prior notification of surgery is required under item A, subitem (3), the 2.17 insurer may require that the employee obtain a second opinion from a physician of the 2.18 employee's choice under Minnesota Statutes, section 176.135, subdivision 1a. If within 2.19 seven working days of the prior notification the insurer notifies the employee and health 2.20 care provider that a second opinion is required, the health care provider may not perform 2.21 the nonemergency surgery until the employee provides the second opinion to the insurer. 2.22 Except as otherwise provided in parts 5221.6200, subpart 6, items B and C; 5221.6205, 2.23 subpart 6, items B and C; 5221.6210, subpart 6, items B and C; 5221.6300, subpart 6, 2.24 item B; and 5221.6305, subpart 3, item B, if the insurer denies authorization within seven 2.25 working days of receiving the second opinion, the health care provider may elect to 2.26

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3.1	perform the surgery, subject to a determination of compensability by the commissioner		
3.2	or compensation judge under subpart 7.		
3.3	[For text of subitems (6) and (7), see M.R.]		
3.4	[For text of subps 10 and 11, see M.R.]		
3.5	5221.6100 PARAMETERS FOR MEDICAL IMAGING.		
3.6	[For text of subp 1, see M.R.]		
3.7	Subp. 2. Specific imaging procedures for low back pain. Except for the emergency		
3.8	evaluation of significant trauma, a health care provider must document in the medical		
3.9	record an appropriate history and physical examination, along with a review of any		
3.10	existing medical records and laboratory or imaging studies regarding the patient's		
3.11	condition, before ordering any imaging study of the low back.		
3.12	[For text of item A, see M.R.]		
3.13	B. Magnetic resonance imaging (MRI) scanning is indicated any time that one		
3.14	of the following conditions is met:		
3.15	(1) when cauda equina syndrome is suspected;		
3.16	(2) for evaluation of progressive neurologic deficit;		
3.17	(3) when previous spinal surgery to the lumbar spine has been performed		
3.18	and there is a need to differentiate scar due to previous surgery from disc herniation,		
3.19	tumor, or hemorrhage; or		
3.20	(4) suspected discitis.		
3.21	Except as specified in subitems (1) to (4), MRI scanning is not indicated in the first		
3.22	eight weeks after an injury.		
3.23	Magnetic resonance imaging scanning is indicated after eight weeks if the patient		
3.24	continues with symptoms and physical findings after the course of initial nonsurgical care		
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4.1	and if the patient's condition prevents the	resumption of the r	egular activities of	daily
4.2	life including regular vocational activities	S.		
4.3	C. Myelography is indicated in the	e following circumst	ances:	
4.4	(1) may be substituted for othe	rwise indicated CT	scanning or MRI sca	anning
4.5	in accordance with items A and B, if thos	e imaging modalitie	es are not locally ava	uilable;
4.6	(2) in addition to CT scanning	or MRI scanning, if	there are is progres	ssive
4.7	neurologic deficits or changes deficit and	CT scanning or MI	RI scanning has bee	'n
4.8	negative; or			
4.9	(3) for preoperative evaluation	in cases of surgical	intervention, but or	ıly if
4.10	CT scanning or MRI scanning have failed	to provide a definit	te preoperative diag	nosis.
4.11	D. Computed tomography myelog	raphy is indicated i	n the following	
4.12	circumstances:			
4.13	(1) the patient's condition is pr	edominantly sciatica	a, and there has bee	n
4.14	previous spinal surgery to the lumbar spin	ne, and tumor is sus	pected;	
4.15	(2) the patient's condition is pr	edominantly sciatic	a and there has beer	1
4.16	previous spinal surgery to the lumbar spin	ne and MRI scannin	g is equivocal;	
4.17	(3) when spinal stenosis is sus	pected and the CT of	or MRI scanning is	
4.18	equivocal;			
4.19	(4) in addition to CT scanning	or MRI scanning, if	there are is progres	ssive
4.20	neurologic symptoms or changes deficit a	and CT scanning or	MRI scanning has b	been
4.21	negative; or			
4.22	(5) for preoperative evaluation	in cases of surgical	intervention, but or	ıly if
4.23	CT scanning or MRI scanning have failed	d to provide a definit	te preoperative diag	nosis.

E. Intravenous enhanced CT scanning is indicated only if there has been 5.1 previous spinal surgery to the lumbar spine, and the imaging study is being used to 5.2 differentiate scar due to previous surgery from disc herniation or tumor, but only if 5.3 intrathecal contrast for CT-myelography is contraindicated and MRI scanning is not 5.4 available or is also contraindicated. 5.5 F. Gadolinium enhanced MRI scanning is indicated when: 5.6 (1) there has been previous spinal surgery to the lumbar spine, and the 5.7 imaging study is being used to differentiate scar due to previous surgery from disc 5.8 herniation or tumor; 5.9 (2) hemorrhage is suspected; 5.10 (3) tumor or vascular malformation is suspected; 5.11 (4) infection or inflammatory disease is suspected; or 5.12 (5) unenhanced MRI scanning was equivocal. 5.13 G. Discography is indicated when: 5.14 [For text of subitem (1), see M.R.] 5.15 5.16 (2) there has been previous spinal surgery to the lumbar spine, and pseudoarthrosis, recurrent disc herniation, annular tear, or internal disc disruption is 5.17 suspected. 5.18 [For text of items H to M, see M.R.] 5.19 **5221.6105 MEDICATIONS.** 5.20 Subpart 1. Scope. Subparts 2 to 4 apply to use of medication in an outpatient setting. 5.21 Subparts 2 to 4 do not require a physician to prescribe any class of drugs in the treatment 5.22 of any patient. 5.23 5 5221.6105

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6.1	Subp. 2. Nonsteroidal anti-inflammatory drugs (NSAID's). Nonsteroidal
6.2	anti-inflammatory drugs (NSAID's) are drugs with analgesic, antipyretic, and
6.3	anti-inflammatory effects. The term "nonsteroidal" is used to distinguish these drugs from
6.4	steroids. NSAID's act as inhibitors of the enzyme cyclooxygenase. For the purposes
6.5	of this subpart, NSAID's include diflunisal but not other salicylates or acetaminophen.
6.6	NSAID's can be divided into two groups, nonselective NSAID's and COX-2 inhibitors.
6.7	Examples of nonselective NSAID's include diclofenac, diflunisal, etodolac, fenoprofen,
6.8	flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meclofenamate, mefenamic
6.9	acid, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, sulindac, and tolmetin.
6.10	An example of a COX-2 inhibitor is celecoxib.
6.11	A. NSAID's are indicated for the symptomatic relief of acute and chronic
6.12	musculoskeletal pain. NSAID's must be prescribed at the lowest clinically effective dose,
6.13	as determined by the prescribing health care provider, but not to exceed the manufacturer's
6.14	maximum daily dosage.
6.15	B. When treating musculoskeletal pain, a generic nonselective NSAID is
6.16	indicated unless a COX-2 inhibitor is indicated as specified in item C.
6.17	(1) When a nonselective NSAID is used, treatment must begin with generic
6.18	ibuprofen or generic naproxen. If there is a medical contraindication documented by the
6.19	prescribing health care provider to each of the medications in this item, then treatment
6.20	may begin with any other generic nonselective NSAID.
6.21	(2) Other generic nonselective NSAID's are not indicated unless one-week
6.22	trials of each of ibuprofen and naproxen have been ineffective in reducing the patient's
6.23	pain by at least 50 percent as determined by the prescribing health care provider.
6.24	(3) Nonselective NSAID's that are not available as generics are not
6.25	indicated.
6.26	C. A COX-2 inhibitor may be indicated instead of a nonselective NSAID for:

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7.1	(1) patients c	over 60 years of age;		
7.2	(2) patients v	vith a history of gastrointestinal bl	eeding or peptic ulcer	
7.3	disease; or			
7.4	(3) patients v	with a history of gastrointestinal side	le effects with nonselec	tive
7.5	NSAID use.			
7.6	However, for any pa	tient meeting any of the criteria of	Subitems (1) to (3) who	<u>o is</u>
7.7	taking aspirin or who is	at an increased risk of cardiovasc	ular disease, a COX-2 ir	nhibitor
7.8	is not indicated and a n	onselective NSAID is indicated as	allowed in items A and	<u>1 B,</u>
7.9	together with gastropro	tective medication.		
7.10	D. NSAID's are	indicated only for the shortest dura	tion needed as determin	ned by
7.11	the prescribing health c	are provider.		
7.12	(1) NSAID's	prescribed within the first four we	eks after the date of inju	ury
7.13	are limited to no more	han two weeks of medication per	prescription or refill.	
7.14	(2) NSAID's	prescribed more than four weeks	after the date of injury n	nay
7.15	not be for more than or	e month of medication per prescri	otion or refill.	
7.16	(3) NSAID's	prescribed more than 12 months a	fter the date of injury m	nay
7.17	not be for more than the	ree months of medication per press	ription or refill.	
7.18	Subp. 3. Opioid an	algesics. An opioid is any agent the	nat binds to opioid recept	otors.
7.19	There are three broad c	lasses of opioids: opium alkaloids,	such as morphine and c	codeine;
7.20	semisynthetic opioids s	uch as heroin and oxycodone; and	fully synthetic opioids s	such as
7.21	pethidine and methador	ne. Opioid analgesics include code	ine, hydrocodone, levor	phanol <u>,</u>
7.22	methadone, morphine,	hydromorphone, and oxycodone.		
7.23	<u>A.</u> Opioid analg	esics are indicated for the sympton	natic relief of acute and	ł
7.24	chronic pain that has be	een inadequately relieved by nono	pioid medications. Opic	oid

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8.1	analgesics must be prescribed at the lo	west clinically effective	ve dose, as determine	ed by the
8.2	prescribing health care provider.			
8.3	\underline{B} . When treating pain, a generi	c oral opioid analgesio	c is indicated.	
8.4	(1) When an oral opioid and	algesic is used for the	symptomatic relief c	<u>of</u>
8.5	acute or chronic pain, treatment must	begin with one of the	following: generic co	odeine,
8.6	generic hydrocodone, generic oxycodo	one, or generic morphi	ne, unless there is a r	medical
8.7	contraindication documented by the pr	escribing health care	provider. If there is a	medical
8.8	contraindication documented by the p	rescribing health care	provider to each of t	he
8.9	medications in this item, then treatment	nt may begin with any	other generic oral of	pioid
8.10	analgesic.			
8.11	(2) Other generic opioid and	algesics are not indica	ted for oral use for th	he
	symptomatic relief of acute or chronic			
8.12		-		
8.13	oxycodone, and morphine have been i			at least
8.14	50 percent as determined by the prese	ribing health care prov	<u>'Ider.</u>	
8.15	(3) Generically available co	mbinations of an oral	opioid and a nonopio	oid
8.16	analgesic may be prescribed instead of	f that opioid analgesic	as otherwise allowed	1 under
8.17	subitems (1) and (2).			
8.18	(4) Oral opioid analgesics t	hat are not available (as generics and	
	<u> </u>			vailabla
8.19	combinations of an oral opioid analge		argesic that are not a	vallable
8.20	as generics are not indicated.			
8.21	<u>C.</u> <u>A course of oral opioid anal</u>	gesics or combination	of an oral opioid and	d a
8.22	nonopioid analgesic is limited as prov	ided in subitems (1) to	<u>v (3).</u>	
				.1
8.23	(1) Oral opioid analgesics p			
8.24	date of injury are limited to no more the	nan two weeks of med	ication per prescription	<u>on.</u>

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9.1	(2) Oral opi	oid analgesics prescribed more	than four weeks after the date of	•
9.2	injury may not be for	more than one month of medicat	tion per prescription.	
9.3	(3) Oral oni	oid analgesics prescribed more	than 12 weeks after the injury	
9.3 9.4			escription if there has been a clin	ical
9.5			rescription and a clinical evaluation	
9.6		ths thereafter during continued u		
9.0			ise of optice unargeores.	
9.7	D. Meperidine	is not indicated in the treatment	of acute or chronic pain.	
9.8	E. Transcutane	ous opioid analgesics are only in	ndicated in patients with a	
9.9	documented disorder	that prevents adequate oral dosir	<u>1g.</u>	
0.10		and hundred monometions of	no only indicated for the tracture	
9.10			re only indicated for the treatmen	<u>n</u>
9.11		and only in patients with a docu	mented disorder that prevents	
9.12	adequate dosing with	swallowed medications.		
9.13	Subp. 4. Muscle r	elaxants. A muscle relaxant is a	a drug which decreases the tone	
9.14	of a muscle. For the p	purposes of this subpart, muscle	relaxants include carisoprodol,	
9.15	chlorzoxazone, cyclob	penzaprine, metaxalone, methoca	arbamol, orphenadrine, and tizan	ide.
9.16	This subpart does not	limit the use of medications that	may be used to treat spasticity.	
9.17	A. Muscle relation	xants are indicated for the symp	ptomatic relief of acute and	
9.18			be prescribed at the lowest clinic	ally
9.19	effective dose, as dete	rmined by the prescribing health	n care provider, but not to exceed	1
9.20	the manufacturer's ma	ximum daily dosage.		
0.01	D Wilson toget			
9.21	B. when treath	ng musculoskeletal pain, a gener	te muscle relaxant is indicated.	
9.22	(1) When a	muscle relaxant is used, treatme	ent must begin with one of the	
9.23	following: generic car	isoprodol, generic chlorzoxazon	e, generic cyclobenzaprine, gene	eric
9.24	methocarbamol, or get	neric tizanide. If there is a medie	cal contraindication documented	by
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10.1	the prescribing health care provide	er to each of the medica	tions in this item, the	en treatment
10.2	may begin with any other generic	muscle relaxant.		
10.3	(2) Metaxolone and orp	henadrine are not indic	ated unless one-wee	k trials
10.4	of each of carisoprodol, chlorzoxa	zone, cyclobenzaprine,	methocarbamol, and	d tizanide
10.5	have been ineffective in reducing	the patient's pain by at 1	east 50 percent as de	etermined by
10.6	the prescribing health care provide	er.		
10.7	(3) Generically availabl	e combinations of a m	uscle relaxant and a	<u>n</u>
10.8	analgesic may be prescribed instea	ad of that muscle relaxa	int as otherwise allow	wed under
10.9	subitems (1) and (2).			
10.10	(4) Muscle relaxants that	at are not available as g	enerics, and combin	ations of
10.11	a muscle relaxant and an analgesic	e that are not available a	as generics, are not in	ndicated.
10.12	C. A course of muscle relation	xants or combination o	f a muscle relaxant a	and an
10.13	analgesic is limited as provided in	subitems (1) to (3) .		
10.14	(1) Muscle relaxants pro	escribed within the first	four weeks after the	e date of
10.15	injury are limited to no more than	two weeks of medication	on per prescription o	r refill.
10.16	(2) Muscle relaxants pro	escribed more than four	weeks after the date	e of injury
10.17	are limited to no more than one more	onth's worth of medicat	ion per prescription	or refill.
10.18	(3) Treatment with mus	cle relaxants for more	than three consecuti	ve
10.19	months is not indicated.			
10.20	D. Benzodiazepines are not	t indicated as muscle re	elaxants for the symp	otomatic
10.21	relief of acute and chronic muscul	oskeletal pain.		
10.22	5221.6200 LOW BACK PAIN.			
10.23	Subpart 1. Diagnostic procedu	ures for treatment of l	ow back injury. A l	nealth care
10.24	provider shall determine the nature	e of the condition befor	e initiating treatmen	t.

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A. An appropriate history and physical examination must be performed and 11.1 documented. Based on the history and physical examination the health care provider must 11.2 assign the patient at each visit to the appropriate clinical category according to subitems 11.3 (1) to (4). The diagnosis must be documented in the medical record. For the purposes 11.4 of subitems (2) and (3), "radicular pain" means pain radiating distal to the knee, or pain 11.5 conforming to a dermatomal distribution and accompanied by anatomically congruent 11.6 motor weakness or reflex changes. This part does not apply to fractures of the lumbar 117 spine, or back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, 11.8 visceral, or neoplastic disease process. 11.9

(1) Regional low back pain, includes referred pain to the leg above the 11.10 knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied 11.11 by anatomically congruent motor weakness or reflex changes. Regional low back pain 11.12 11.13 includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses 11.14 for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of 11.15 the lumbar spine or sacroiliac joints and which effects the lumbosacral region, with or 11.16 without referral to the buttocks and/or leg above the knee, including, but not limited to, 11.17 ICD-9-CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 11.18 722.51, 722.52, 722.6, 722.8, 722.80, 722.83, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 11.19 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 846.0, 11.20 847.2 to 847.9, 922.3, 922.31, 926.1, 926.11, and 926.12. 11.21

(2) Radicular pain, with or without regional low back pain, with static or
no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral
radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc
with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy,
radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the leg below the
knee believed to originate with irritation of a nerve root in the lumbar spine, including, but

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13.1	(1) Functional capac	city assessment or evaluation	m A comprehensive F	<u>CE</u> is
13.2	not indicated during the period	l of initial nonsurgical man	agement.	
13.3	(2) After the period	of initial nonsurgical mana	gement functional car	pacity
13.4	assessment or evaluation, a co	mprehensive FCE is indica	ted in either of the fol	lowing
13.5	circumstances:			
13.6	(a) <u>permanent</u> ac	ctivity restrictions and capal	oilities must be identif	ied; or
13.7	(b) there is a que	estion about the patient's ab	lity to do a specific jo	b.
13.8	(3) A functional cap	pacity evaluation comprehen	<u>nsive FCE</u> is not appro	opriate
13.9	indicated to establish baseline	performance before treatm	ent , or for subsequent	ŧ
13.10	assessments, to evaluate chang	ge <u>in performance</u> during or	after a course of treat	ment.
13.11	(4) Only one compl	eted functional capacity eva	uluation comprehensiv	ve FCE
13.12	is indicated per injury.			
13.13	(5) Functional tests	or physical performance te	sts done as part of a v	vork
13.14	conditioning program or work	hardening program as prov	ided in part 5221.660	0, subpart
13.15	2, item D, or in conjunction w	ith active treatment modalit	ies as provided in sub	part 4, are
13.16	not a comprehensive FCE and	are not limited by this iten	<u>l.</u>	
13.17		[For text of item J, see M.I	<u>.]</u>	
13.18]	[For text of subp 2, see M.]	<u>₹.]</u>	
13.19	Subp. 3. Passive treatmen	nt modalities.		
13.20	[Fo	r text of items A to D, see	<u>M.R.]</u>	
13.21	E. Electrical muscle sti	mulation includes muscle s	timulation, low-volt th	nerapy,
13.22	sine wave therapy, stimulation	n of peripheral nerve, galva	nic stimulation, TENS	S,
13.23	interferential, and microcurrer	it techniques.		
13.24	[For te	xt of subitems (1) and (2), s	see M.R.]	
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14.1	F. Mechanical traction: is the therapeutic use of mechanically induced tension
14.2	created by a pulling force to produce a combination of distraction and gliding to relieve
14.3	pain and increase flexibility. Mechanical traction may be continuous, static, intermittent,
14.4	inversion, gravity, or positional. Examples of mechanical traction include power traction,
14.5	intersegmental motorized mobilization, vertebral axial decompression, autotraction
14.6	(active), and 90/90.
14.7	[For text of subitems (1) and (2), see M.R.]
14.8	G. Acupuncture treatments. Endorphin-mediated analgesic therapy includes
14.9	elassic acupuncture and acupressure:
14.10	[For text of subitems (1) to (3), see M.R.]
14.11	H. Manual therapy includes soft tissue and joint mobilization, therapeutie
14.12	massage, and manual traction, myofascial release, joint mobilization and manipulation,
14.13	manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point
14.14	therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of
14.15	massage:
14.16	[For text of subitems (1) to (3), see M.R.]
14.17	[For text of items I to K, see M.R.]
14.18	[For text of subps 4 to 7, see M.R.]
14.19	Subp. 8. Durable medical equipment. Durable medical equipment is indicated only
14.20	in the situations specified in items A to D. The health care provider must provide prior
14.21	notification as required in items B and C according to part 5221.6050, subpart 9.
14.22	[For text of items A to C, see M.R.]
14.23	D. The following durable medical equipment is not indicated for home use for
14.24	any of the low back conditions described in subpart 1, item A:

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[For text of subitems (1) and (2), see M.R.]

15.2

[For text of subp 9, see M.R.]

Subp. 10. Scheduled and nonscheduled medication. Prescription of controlled 15.3 substance medications scheduled under Minnesota Statutes, section 152.02, including 15.4 without limitation, narcotics, is indicated only for the treatment of severe acute pain. 15.5 These medications are not indicated in the treatment of patients with regional low back 15.6 pain after the first two weeks. 15.7 Patients with radicular pain may require longer periods of treatment. 15.8 The health care provider must document the rationale for the use of any scheduled 15.9 15.10 medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued must 15.11 comply with all of the applicable parameters in part 5221.6105. The prescribing health 15.12 care provider must determine that ongoing medication is effective treatment for the 15.13 patient's condition and that the most cost-effective regimen is used. 15.14 [For text of subps 11 to 13, see M.R.] 15.15

15.16 **5221.6205 NECK PAIN.**

15.17 Subpart 1. Diagnostic procedures for treatment of neck injury. A health care
15.18 provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the shoulder. This part does not apply to fractures of the cervical spine or cervical pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

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(1) Regional neck pain includes referred pain to the shoulder and upper 16.1 back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial 16.2 syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain 16.3 believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical 16.4 spine and which affects the cervical region, with or without referral to the upper back or 16.5 shoulder, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 16.6 to 721.90, 722.0, 722.2, 722.3 to 722.30, 722.39, 722.4, 722.6, 722.8, 722.80, 722.81, 16.7 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 16.8 738.2, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 847.9, 920, 922.3, 925, and 16.9 926.1 to 926.12 926.11. 16.10

(2) Radicular pain, with or without regional neck pain, with no or static 16.11 neurologic deficit. This includes the diagnoses of brachialgia; cervical radiculopathy, 16.12 radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, 16.13 radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other 16.14 diagnoses for pain in the arm distal to the shoulder believed to originate with irritation 16.15 16.16 of a nerve root in the cervical spine, including, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 722.8, 722.80, 722.81, 723.4, and 16.17 724 to 724.00, and 724.9. In these cases neurologic findings on history and examination 16.18 are either absent or do not show progressive deterioration. 16.19

(3) Radicular pain, with or without regional neck pain, with progressive
neurologic deficit, which includes the same diagnoses as subitem (2); however, in these
cases there is a history of progressive deterioration in the neurologic symptoms and
physical findings, including worsening sensory loss, increasing muscle weakness, and
progressive reflex changes.

16.25 (4) Cervical compressive myelopathy, with or without radicular pain, is16.26 a condition characterized by weakness and spasticity in one or both legs and associated

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with any of the following: exaggerated reflexes, an extensor plantar response, bowel or
bladder dysfunction, sensory ataxia, or bilateral sensory changes. <u>Cervical compressive</u>
myelopathy includes the ICD-9-CM code 336.9.

[For text of items B to H, see M.R.]

17.5 I. A comprehensive functional capacity assessment or evaluation (FCE) is a comprehensive and objective assessment of a patient's ability to perform work tasks 17.6 an individualized examination and evaluation that objectively measures the patient's 17.7 current level of function and the ability to perform functional or work-related tasks, and it 17.8 17.9 predicts the potential to sustain these tasks over a defined time frame. The components of a functional capacity assessment or evaluation comprehensive FCE include, but are not 17.10 necessarily limited to, neuromusculoskeletal screening, tests of manual material handling, 17.11 assessment of functional mobility, and measurement of postural tolerance. A functional 17.12 17.13 capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested 17.14 information. Functional capacity assessments and evaluations are performed to determine 17.15 a patient's physical capacities in general or to determine and report work tolerance for a 17.16 specific job, task, or work activity. 17.17

- 17.18 (1) Functional capacity assessment or evaluation <u>A comprehensive FCE</u>
 17.19 is not reimbursable indicated during the period of initial nonoperative care nonsurgical
 17.20 management.
- 17.21 (2) Functional capacity assessment or evaluation <u>After the period of initial</u>
 17.22 <u>nonsurgical management, a comprehensive FCE is reimbursable indicated in either of the</u>
 17.23 following circumstances:
- (a) permanent activity restrictions and capabilities must be identified; or(b) there is a question about the patient's ability to do a specific job.

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18.1	(3) A comprehensi	ive FCE is not indicated to es	tablish baseline perfo	rmance
18.2	before treatment or to evalua	te change in performance dur	ing a course of treatm	ient.
18.3	(4) Only one comp	pleted comprehensive FCE is	indicated per injury.	
18.4	(5) Functional test	s or physical performance tes	ts done as part of a w	vork
18.5	conditioning program or wor	k hardening program as provi	ded in part 5221.660	0, subpart
18.6	2, item D, or in conjunction	with active treatment modaliti	es as provided in sub	part 4, are
18.7	not a comprehensive FCE an	d are not limited by this item	<u>-</u>	
18.8		[For text of item J, see M.R]	
18.9		[For text of subp 2, see M.R	<u>.</u>]	
18.10	Subp. 3. Passive treatme	ent modalities.		
18.11	[Fc	or text of items A and D, see	<u>M.R.]</u>	
18.12	E. Electrical muscle s	timulation includes muscle st	imulation, low-volt th	ierapy,
18.13	sine wave therapy, stimulation	on of peripheral nerve, galvar	nic stimulation, TENS	5,
18.14	interferential, and microcurre	ent techniques.		
18.15	[For t	text of subitems (1) and (2), s	ee M.R.]	
18.16	F. Mechanical traction	n: is the therapeutic use of me	chanically induced to	ension
18.17	created by a pulling force to	produce a combination of dis	traction and gliding to	o relieve
18.18	pain and increase flexibility.	Mechanical traction may be c	continuous, static, inte	ermittent,
18.19	inversion, gravity, or position	nal. Examples of mechanical	traction include powe	r traction,
18.20	intersegmental motorized mo	obilization, vertebral axial dec	compression, autotrac	tion
18.21	(active), and 90/90.			
18.22	[For t	text of subitems (1) and (2), s	ee M.R.]	
18.23	G. Acupuncture treatment	nents. Endorphin-mediated a	nalgesie therapy inch	ides
18.24	elassic acupuncture and acup	oressure:		

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19.1	[For text of subitems (1) to (3), see M.R.]
19.2	H. Manual therapy includes soft tissue and joint mobilization, therapeutie
19.3	massage, and manual traction, myofascial release, joint mobilization and manipulation,
19.4	manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point
19.5	therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of
19.6	massage:
19.7	[For text of subitems (1) to (3), see M.R.]
19.8	[For text of items I to K, see M.R.]
19.9	[For text of subps 4 to 7, see M.R.]
19.10	Subp. 8. Durable medical equipment. Durable medical equipment is indicated only
19.11	as specified in items A to D. The health care provider must provide prior notification as
19.12	required in items B and C according to part 5221.6050, subpart 9.
19.13	[For text of items A to C, see M.R.]
19.14	D. The following durable medical equipment is not indicated for home use for
19.15	any of the neck pain conditions described in subpart 1, item A:
19.16	[For text of subitems (1) and (2), see M.R.]
19.17	[For text of subp 9, see M.R.]
19.18	Subp. 10. Scheduled and nonscheduled medication. Prescription of controlled
19.19	substance medications scheduled under Minnesota Statutes, section 152.02, including,
19.20	without limitation, narcotics, is indicated only for the treatment of severe acute pain.
19.21	These medications are not indicated in the treatment of patients with regional neck pain
19.22	after the first two weeks.
19.23	Patients with radicular pain may require longer periods of treatment.
19.24	The health care provider must document the rationale for the use of any scheduled
19.25	medication. Treatment with nonnarcotic medication may be appropriate during any phase
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20.1	of treatment and intermittently after	all other treatment h	as been discontinued m	ust
20.2	comply with all of the applicable pa	rameters in part 5221	.6105. The prescribing	health
20.3	care provider must determine that o	ngoing medication is	effective treatment for	the
20.4	patient's condition and the most cost	t-effective regimen is	used.	
20.5	[For text of	of subps 11 to 14, see	<u>. M.R.]</u>	
20.6	5221.6210 THORACIC BACK PA	AIN.		
20.7	Subpart 1. Diagnostic procedur	es for treatment of t	horacic back injury. A	A health
20.8	care provider shall determine the nat	ture of the condition	before initiating treatme	ent.
20.9	A. An appropriate history an	nd physical examination	on must be performed a	and
20.10	documented. Based on the history as	nd physical examinat	ion the health care prov	ider must
20.11	assign the patient at each visit to the	consistency appropri	ate clinical category acc	cording to
20.12	subitems (1) to (4). The diagnosis n	nust be documented i	n the medical record. F	or the
20.13	purposes of subitems (2) and (3), "ra	adicular pain" means	pain radiating in a dern	natomal
20.14	distribution around the chest or abdo	omen. This part does	not apply to fractures of	of the
20.15	thoracic spine or thoracic back pain	due to an infectious,	immunologic, metabol	ic,
20.16	endocrine, neurologic, visceral, or n	eoplastic disease pro-	cess.	
20.17	(1) Regional thoracic bac	k pain includes the c	liagnoses of thoracic str	ain,
20.18	sprain, myofascial syndrome, muscu	loligamentous injury	y, soft tissue injury, and	any
20.19	other diagnosis for pain believed to	originate in the discs	, ligaments, muscles, or	other
20.20	soft tissues of the thoracic spine and	which effects the the	pracic region, including	, but not
20.21	limited to, ICD-9-CM codes 720 to	720.9, 721 to 721.0, 7	721.5 to 721.90, 722.3 t	o 722.30,
20.22	722.4, 722.6, 722.9 to 722.91, 723 t	o 723.3, 723.5 to 723	.9, 724.5, 724.8, 724.9,	732.0,
20.23	737 to 737.9, 738.4, 738.5, 739.1, 7	56.1 to 756.19, 847 t	o 847.0, 920, 922.3, 92	5, and
20.24	926.1 to 926.12.			

20.25 (2) Radicular pain, with or without regional thoracic back pain, includes
20.26 the diagnoses of thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation

of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with 21.1 radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to 21.2 originate with irritation of a nerve root in the thoracic spine, including, but not limited 21.3 to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, 21.4 and 724 to 724.00. 21.5 (3) Thoracic compressive myelopathy, with or without radicular pain, is 21.6 a condition characterized by weakness and spasticity in one or both legs and associated 21.7 with any of the following: exaggerated reflexes, an extensor plantar response, bowel or 21.8 bladder dysfunction, sensory ataxia, or bilateral sensory changes. Thoracic compressive 21.9 myelopathy includes the ICD-9-CM code 336.9. 21.10 [For text of items B to H, see M.R.] 21.11 I. A comprehensive functional capacity assessment or evaluation (FCE) is 21.12 a comprehensive and objective assessment of a patient's ability to perform work tasks 21.13 an individualized examination and evaluation that objectively measures the patient's 21.14 current level of function and the ability to perform functional or work-related tasks, and it 21.15 predicts the potential to sustain these tasks over a defined time frame. The components of 21.16 a functional capacity assessment or evaluation comprehensive FCE include, but are not 21.17 limited to, neuromusculoskeletal screening, tests of manual material handling, assessment 21.18 21.19 of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and 21.20 measurements are determined by the patient's condition and the requested information. 21.21 Functional capacity assessments and evaluations are performed to determine and report 21.22 a patient's physical capacities in general or to determine work tolerance for a specific 21.23 21.24 job, task, or work activity.

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22.1	(1) Functional capacity	y assessment or evaluation	m A comprehensive F	CE
22.2	is not reimbursable indicated dur	ing the period of initial r	onoperative care none	surgical
22.3	management.			
22.4	(2) Functional capacity	y assessment or evaluation	n After the period of	initial
22.5	nonsurgical management, a comp	orehensive FCE is reimbu	ursable indicated in eit	her of the
22.6	following circumstances:			
22.7	(a) permanent activ	vity restrictions and capat	oilities must be identifi	ied; or
22.8	(b) there is a questi	on about the patient's abi	lity to do a specific jo	b.
22.9	(3) <u>A comprehensive I</u>	FCE is not indicated to es	tablish baseline perfo	rmance
22.10	before treatment or to evaluate cl	nange in performance du	ring a course of treatm	ent.
22.11	(4) Only one complete	d comprehensive FCE is	indicated per injury.	
22.12	(5) <u>Functional tests or</u>	physical performance tes	sts done as part of a w	vork
22.13	conditioning program or work hardening program as provided in part 5221.6600, subpart			
22.14	2, item D, or in conjunction with	active treatment modalit	ies as provided in sub	part 4, are
22.15	not a comprehensive FCE and ar	e not limited by this item	<u>l.</u>	
22.16	[Fe	or text of item J, see M.F	<u>.]</u>	
22.17	[Fo	or text of subp 2, see M.I	ξ.]	
22.18	Subp. 3. Passive treatment	modalities.		
22.19	[For to	ext of items A to D, see	<u>M.R.]</u>	
22.20	E. Electrical muscle stimu	lation includes muscle st	imulation, low-volt th	ierapy,
22.21	sine wave therapy, stimulation o	f peripheral nerve, galva	nic stimulation, TENS	5,
22.22	interferential, and microcurrent t	echniques.		
22.23	[For text	of subitems (1) and (2), s	ee M.R.]	

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23.1	F. Mechanical traction: is the t	herapeutic use of me	chanically induced ter	nsion
23.2	created by a pulling force to produce a	a combination of dis	traction and gliding to	relieve
23.3	pain and increase flexibility. Mechani	cal traction may be c	ontinuous, static, inter	rmittent,
23.4	inversion, gravity, or positional. Exam	ples of mechanical t	raction include power	traction,
23.5	intersegmental motorized mobilization	n, vertebral axial dec	compression, autotract	tion
23.6	(active), and 90/90.			
23.7	[For text of sul	bitems (1) and (2), so	ee M.R.]	
23.8	G. Acupuncture treatments. Er	ndorphin-mediated a	nalgesic therapy inclu	des
23.9	elassic acupuncture and acupressure:			
23.10	[For text of su	ubitems (1) to (3), se	e M.R.]	
23.11	H. Manual therapy includes soft tissue and joint mobilization, therapeutie			
23.12	massage, and manual traction, myofascial release, joint mobilization and manipulation,			
23.13	manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point			
23.14	therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of			
23.15	massage:			
23.16	[For text of su	ubitems (1) to (3), se	e M.R.]	
23.17	[For text o	f items I to K, see M	<u>I.R.]</u>	
23.18	[For text o	f subps 4 to 7, see M	<u>I.R.]</u>	
23.19	Subp. 8. Durable medical equipm	nent. Durable medic	al equipment is indica	ated only
23.20	in certain specific situations, as specifi	ied in items A to D.	The health care provid	ler must
23.21	provide the insurer with prior notifica	tion as required by it	ems B and C, accordi	ng to
23.22	part 5221.6050, subpart 9.			
23.23	[For text of	f items A to C, see M	<u>/I.R.]</u>	
23.24	D. The following durable medi	cal equipment is not	indicated for home us	se for
23.25	any of the thoracic back pain conditio	ns described in subp	art 1, item A:	
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24.8 Patients with radicular pain may require longer periods of treatment.

24.9 The health care provider must document the rationale for the use of any scheduled

24.10 medication. Treatment with nonnarcotic medication may be appropriate during any phase

24.11 of treatment and intermittently after all other treatment has been discontinued must

24.12 <u>comply with all of the applicable parameters in part 5221.6105</u>. The prescribing health

24.13 care provider must determine that ongoing medication is effective treatment for the

24.14 patient's condition and the most cost-effective regimen is used.

24.15

[For text of subps 11 to 13, see M.R.]

24.16 **5221.6300 UPPER EXTREMITY DISORDERS.**

24.17 Subpart 1. **Diagnostic procedures for treatment of upper extremity disorders**

24.18 (UED). A health care provider shall determine the nature of an upper extremity disorder
24.19 before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must at each visit assign the patient to the appropriate clinical category according to subitems (1) to (6). The diagnosis must be documented in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This part does not apply to upper extremity conditions due to a visceral, vascular, infectious,

07/10/09 REVISOR SWN/PT RD3721 immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, 25.1 fractures, lacerations, amputations, or sprains or strains with complete tissue disruption. 25.2 (1) Epicondylitis. This clinical category includes medial epicondylitis and 25.3 lateral epicondylitis, ICD-9-CM codes 726.31 and 726.32. 25.4 (2) Tendonitis of the forearm, wrist, and hand. This clinical category 25.5 encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, 25.6 tendon sheath, tendon insertion, or musculotendinous junction in the upper extremity at 25.7 or distal to the elbow due to mechanical injury or irritation, including, but not limited 25.8 to, the diagnoses of tendonitis, tenosynovitis, tendovaginitis, peritendinitis, extensor 25.9 tendinitis, de Quervain's syndrome, intersection syndrome, flexor tendinitis, and trigger 25.10 digit, including, but not limited to, ICD-9-CM codes 726.4, 726.5, 726.8, 726.9, 726.90, 25.11 727, 727.0, 727.00, 727.03, 727.04, 727.05, and 727.09, 727.2, 727.3, 727.4 to 727.49, 25.12 727.8 to 727.82, 727.89, and 727.9. 25.13

(3) Nerve entrapment syndromes. This clinical category encompasses any
compression or entrapment of the radial, ulnar, or median nerves, or any of their branches,
including, but not limited to, carpal tunnel syndrome, pronator syndrome, anterior
interosseous syndrome, cubital tunnel syndrome, Guyon's canal syndrome, radial tunnel
syndrome, posterior interosseous syndrome, and Wartenburg's syndrome, including, but
not limited to, ICD-9-CM codes 354, 354.0, 354.1, 354.2, 354.3, 354.8, and 354.9.

(4) Muscle pain syndromes. This clinical category encompasses any
painful condition of any of the muscles of the upper extremity, including the muscles
responsible for movement of the shoulder and scapula, characterized by pain and stiffness,
including, but not limited to, the diagnoses of chronic nontraumatic muscle strain,
repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse
syndrome, myofascial pain syndrome, myofasciitis, nonspecific myalgia, fibrositis,

26.1	fibromyalgia, and fibromyositis, including, but not limited to, ICD-9-CM codes 723.3,
26.2	729.0, 729.1, 729.5, 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and 842.
26.3	(5) Shoulder impingement syndromes, including tendonitis, bursitis, and
26.4	related conditions. This clinical category encompasses any inflammation, pain, tenderness,
26.5	dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous
26.6	junction, or bursa in the shoulder due to mechanical injury or irritation, including,
26.7	but not limited to, the diagnoses of impingement syndrome, supraspinatus tendonitis,
26.8	infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis,
26.9	subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendinitis, including, but not
26.10	limited to, ICD-9-CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3,
26.11	840, 840.4, and 840.6 , 840.8, and to 840.9.
26.12	(6) Traumatic sprains or strains of the upper extremity. This clinical
26.13	category encompasses an instantaneous or acute injury, as a result of a single precipitating
26.14	event to the ligaments or the muscles of the upper extremity including, without limitation,
26.15	ICD-9-CM codes 840 to 842.19. Injuries to muscles as a result of repetitive use, or
26.16	occurring gradually over time without a single precipitating trauma, are considered muscle
26.17	pain syndromes under subitem (4). Injuries with complete tissue disruption are not
26.18	subject to this parameter.
26.10	[For taxt of items D to D see M D]
26.19	[For text of items B to D, see M.R.]
26.20	E. The following diagnostic procedures or tests are not indicated for the
26.21	diagnosis of upper extremity disorders any of the clinical categories in item A:
26.22	[For text of subitems (1) to (3), see M.R.]
26.23	[For text of items F to I, see M.R.]
26.24	J. <u>A comprehensive functional capacity assessment or evaluation (FCE)</u> is
26.25	a comprehensive and objective assessment of a patient's ability to perform work tasks

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27.1	an individualized examination and evaluation that abjectivally measures the national
27.1	an individualized examination and evaluation that objectively measures the patient's
27.2	current level of function and the ability to perform functional or work-related tasks, and it
27.3	predicts the potential to sustain these tasks over a defined time frame. The components of
27.4	a functional capacity assessment or evaluation comprehensive FCE include, but are not
27.5	limited to, neuromusculoskeletal screening, tests of manual material handling, assessment
27.6	of functional mobility, and measurement of postural tolerance. A functional capacity
27.7	assessment or evaluation is an individualized testing process and the component tests and
27.8	measurements are determined by the patient's condition and the required information.
27.9	Functional capacity assessments and evaluations are performed to determine and report
27.10	a patient's physical capacities in general or to determine work tolerance for a specifie
27.11	job, task, or work activity.
27.12	(1) Functional capacity assessment or evaluation A comprehensive FCE is
27.13	not indicated during the first 12 weeks period of initial nonsurgical treatment management.
27.14	(2) Functional capacity assessment or evaluation After the period of initial
27.15	nonsurgical management, comprehensive FCE is indicated after the first 12 weeks of care
27.16	in either of the following circumstances:
27.17	(a) <u>permanent</u> activity restrictions and capabilities must be identified; or
27.18	(b) there is a question about the patient's ability to return to do a
27.19	specific job.
27.20	(3) A functional capacity evaluation comprehensive FCE is not appropriate
27.21	indicated to establish baseline performance before treatment, or for subsequent
27.22	assessments, to evaluate change in performance during or after a course of treatment.
27.23	(4) Only one completed functional capacity evaluation comprehensive FCE
27.24	is indicated per injury.

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28.1	(5) Functional tests or physical p	erformance tests don	e as part of a work c	onditioning	
28.2	program or work hardening program as provided in part 5221.6600, subpart 2, item D,				
28.3	or in conjunction with active treatme	ent modalities as prov	vided in subpart 4, a	re not a	
28.4	comprehensive FCE and are not limit	ited by this item.			
28.5	[For te	ext of item K, see M.	<u>R.]</u>		
28.6	[For te	ext of subp 2, see M.	<u>R.]</u>		
28.7	Subp. 3. Passive treatment mod	lalities.			
28.8	[For text	of items A to D, see	<u>M.R.]</u>		
28.9	E. Electrical muscle stimulati	on includes <u>muscle s</u>	timulation, low-volt	therapy,	
28.10	sine wave therapy, stimulation of pe	ripheral nerve, galva	nic stimulation, TE	NS,	
28.11	interferential, and microcurrent technology	niques.			
28.12	[For text of s	ubitems (1) and (2),	see M.R.]		
28.13	F. Acupuncture treatments. E	ndorphin-mediated a	nalgesic therapy inc	ludes	
28.14	elassic acupuncture and acupressure	:			
28.15	[For text of s	subitems (1) to (3), s	ee M.R.]		
28.16	[For te	ext of item G, see M.	<u>R.]</u>		
28.17	H. Manual therapy includes s	oft tissue and joint m	obilization and ther	apeutie	
28.18	massage manual traction, myofascial	l release, joint mobili	zation and manipula	tion, manual	
28.19	lymphatic drainage, soft-tissue mobi	lization and manipul	ation, trigger point t	herapy,	
28.20	acupressure, muscle stimulation - ma	anual (nonelectrical),	and any form of ma	ssage:	
28.21	[For text of s	subitems (1) to (3), s	ee M.R.]		
28.22	[For text	of items I and J, see	<u>M.R.]</u>		
28.23	[For text	of subps 4 to 7, see	<u>M.R.]</u>		

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29.1	Subp. 8. Durable medical equipment. D	Jurable medical	equipment is indicat	ed only
29.2	in the situations specified in items A to D. The	he health care pr	ovider must provide	e the
29.3	insurer with prior notification as required in it	tems B and C an	d part 5221.6050, su	ubpart 9.
29.4	[For text of items A to C, see M.R.]			
29.5	D. The following durable medical equ	ipment is not in	dicated for home use	e for
29.6	the upper extremity disorders specified descri	ibed in subparts	11 to 16 subpart 1, it	tem A:
29.7	[For text of subitems (1) and (2), see M.R.]			
29.8	[For text of sub	op 9, see M.R.]		
29.9	Subp. 10. Scheduled and nonscheduled	medication. Pr	escription of control	lled
29.10	substance medications scheduled under Minn	resota Statutes, s	eetion 152.02, inclu	ding,
29.11	without limitation, narcotics, is indicated only	y for the treatme	ent of severe acute p	ain.
29.12	Therefore, these medications are not routinely	y indicated in the	e treatment of patier	nts with
29.13	upper extremity disorders. The health care pr	rovider must doo	cument the rationale	for
29.14	the use of any scheduled medication. Treatm	ent with nonseho	eduled medication n	nay be
29.15	appropriate during any phase of treatment and	d intermittently a	after all other treatm	ent has
29.16	been discontinued must comply with all of th	e applicable par	ameters in part 5221	.6105.
29.17	The prescribing health care provider must det	termine that ong	oing medication is e	effective
29.18	treatment for the patient's condition and the n	nost cost-effectiv	ve regimen is used.	
29.19	[For text of subps]	11 to 16, see M.I	<u>R.]</u>	
29.20	5221.6305 <u>COMPLEX REGIONAL PAIN</u>			
29.21 29.22	SYMPATHETIC DYSTROPHY; AND CA LOWER EXTREMITIES.	<u>AUSALGIA</u> OF	THE UPPER AN	D
29.23	Subpart 1. Scope.			

A. This clinical category encompasses:

5221.6305

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30.1	(1) any condition diagnose	ed as complex regior	nal pain syndrome, refle	ex
30.2	sympathetic dystrophy, or causalgia,	or any other condition	on included in ICD-9-C	M codes
30.3	337.20, 337.21, 337.22, 337.29, 337.	9, 354.4, 355.71, 35	5.9, or 733.7; or	
30.4	(2) any condition of the up	oper or lower extrem	nity characterized by	
30.5	concurrent presence in the involved e	extremity of five of the	he following conditions	s: edema;
30.6	local skin color change of red or pur	ple; osteoporosis in	underlying bony struct	ures
30.7	demonstrated by radiograph; local dy	shidrosis; local abno	ormality of skin temper	rature
30.8	regulation; reduced passive range of	motion in contiguou	s joints; local alteratio	n of
30.9	skin texture of smooth or shiny; or ty	pical findings of ref	lex sympathetic dystrop	phy on
30.10	bone scan. This clinical category inc	ludes, but is not limi	ted to, the diagnoses o	f reflex
30.11	sympathetic dystrophy, causalgia, Su	dek's atrophy, algone	urodystrophy, and shou	ılder-hand
30.12	syndrome, and including, but not lim	ited to, ICD-9-CM e	odes 337.9, 354.4, and	-733.7. ; or
30.13	(3) any condition of the up	ner or lower extrem	ity that develops after t	trauma
30.14	or nerve injury and is characterized b	by continuing pain, a	llodynia, or hyperalges	1a that 1s
30.15	nonanatomic in distribution and disp	roportionate to the or	riginal injury and to sti	mulation,
30.16	and the patient has or has had edema	, vasomotor abnorma	ality, or sudomotor abn	ormality
30.17	on examination, and there is no other	explanation for the	degree of pain and dys	function.
30.18	[For text o	f items B and C, see	<u>M.R.]</u>	
30.19	Subp 2 Initial nonsurgical ma	nagement. Initial no	onsurgical management	t is

30.19 Subp. 2. **Initial nonsurgical management.** Initial nonsurgical management is 30.20 appropriate for all patients with reflex sympathetic dystrophy and must be the first phase 30.21 of treatment. Any course or program of initial nonsurgical management is limited to 30.22 the modalities specified in items A to D.

30.23 A. Therapeutic injection modalities. The only injections allowed for reflex
30.24 sympathetic dystrophy are sympathetic block, intravenous infusion of steroids or
30.25 sympatholytics, or epidural block.

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31.1	(1) Unless medically contraindicated, sympathetic blocks or the intravenous		
31.2	infusion of steroids or sympatholytics must be used if reflex sympathetic dystrophy has		
31.3	continued for four weeks and the employee remains disabled as a result of the reflex		
31.4	sympathetic dystrophy.		
31.5	(a) Time for treatment response: within 30 minutes.		
31.6	(b) Maximum treatment frequency: can repeat an injection at a site		
31.7	to a limb if there was a positive response to the first injection. If subsequent injections		
31.8	demonstrate diminishing control of symptoms or fail to facilitate objective functional		
31.9	gains, then injections must be discontinued. No more than three injections to different		
31.10	sites limbs are reimbursable per patient visit.		
31.11	[For text of unit (c), see M.R.]		
31.12	[For text of subitem (2), see M.R.]		
31.13	[For text of items B and C, see M.R.]		
31.14	D. Oral medications may be indicated in accordance with accepted medical		
31.15	practice The health care provider must document the rationale for the use of any		
31.16	medication. Treatment with medication may be appropriate during any phase of treatment		
31.17	and must comply with all of the applicable parameters in part 5221.6105. The prescribing		
31.18	health care provider must determine that ongoing medication is effective treatment for the		
31.19	patient's condition and that the most cost-effective regimen is used.		
31.20	[For text of subps 3 and 4, see M.R.]		